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Health Care Finance Working Group – Preliminary Report on Financial Conditions in the Insurance Market

Introduction

Massachusetts residents obtain health coverage in a variety of ways, only some of which are regulated by the state. (See Figure 1.) While many employers purchase insurance products for their employees, a significant proportion of Massachusetts employers, as elsewhere in the U.S., choose instead to self-insure. These self-insured (or self-funded) plans are not subject to state insurance regulation, but rather are regulated under the federal Employee Retirement Income Security Act of 1974, as amended (ERISA), even if the employer contracts with a local health plan to administer the program. (See Table 1.) In addition, the Medicare and Medicaid programs are subject to distinct regulatory systems. It is for the most part those people who are covered by insurance products – i.e., those offered by carriers, including Health Maintenance Organizations (HMOs), that assume the financial risk for providing covered services to enrollees – who are directly affected by state health insurance regulation.

Of the population covered by state-regulated health insurance products, by far the majority are enrolled in the state's four largest health plans[1] – Harvard Pilgrim Health Care, Inc., Fallon Community Health Plan, Inc., Tufts Associated Health, and Blue Cross and Blue Shield of Massachusetts, Inc. (which offers health insurance products in addition to HMO coverage). Because the continuity and predictability of health coverage for a large portion of Massachusetts residents depends on the stability of the four largest health plans, and because the financial stability of Massachusetts plans has been widely questioned in the aftermath of the Harvard Pilgrim Health Care receivership earlier this year, the working group has focused its attention on the financial condition of the Commonwealth's largest plans. Of course, many other insurers and health plans provide coverage in Massachusetts, including many national managed care organizations. Many of the observations in this report may not be applicable to all of the national managed care organizations operating in Massachusetts, since those plans generally have a smaller enrollment in Massachusetts than the four largest plans and some may have access to financial resources of parent companies. Although we concentrate on the largest plans, it is worth noting that almost all of the managed care plans in Massachusetts, regardless of size or ownership, have experienced financial losses in recent years. (See Figure 2.)

In many ways, however, discussion about health plans leads inevitably to a broader discussion of the health care system. Health plans are at the center of many of the tensions exerted by the various parts of the health care system and its many stakeholders – employers' and other payers' desire to keep premiums affordable, providers' need for adequate payments, and consumers' desire for access to services and providers at no or

[1] Throughout this draft, the terms "health plans," "plans" and "managed care organizations" are used to refer to Health Maintenance Organizations licensed under M.G.L. c. 176G as well as Blue Cross and Blue Shield of Massachusetts.

low additional cost. Premiums in Massachusetts were relatively steady for several years in the 1990s, but the costs of the health care delivery system continued and still continue to increase. Recent premium increases appear to be necessary to help improve the solvency of our health plans and pay medical costs that continue to rise, but they will also increase costs to employers and consumers and may lead to increases in the numbers of people without insurance. There is a tension between rebuilding reserves[2] by increasing plan revenue or reducing costs of care or administration. Even if it is accepted that premium increases are necessary, it is also important to consider how the incremental revenues should be used. Should they be passed on to providers, or should they be used to improve the solvency of health plans by building reserves? If the state implements specific continuing reserve requirements for plans to enhance their financial stability, improved operating results could be used to meet those reserve requirements, at least in the short run. While instituting such reserve requirements may be an appropriate step towards enhancing stability among plans, will it limit their ability to pay providers adequately? While this report is focused on the four largest plans, it should be read in the context of these broader health care financing issues.

Profile of the Market

The Massachusetts health insurance market is characterized by at least the following features:

- A large proportion of the population covered by employer-provided insurance is enrolled in managed care products. (See Figure 3.)

- Dominance by a limited number of nonprofit pre-paid health plans, or HMOs, as opposed to traditional insurers. (See Figures 4 and 5) Although there has been significant consolidation in the health insurance market in many other regions of the country, Massachusetts is unusual in the dominance of our market by locally controlled nonprofit managed care plans. The tradition in Massachusetts of pre-paid health care plans growing out of medical schools or group practices is longstanding, much like our tradition of heavy reliance on teaching hospitals. However, the close integration of health plans and large groups practices has eroded with the rise of more diffuse forms of health plan provider networks, such as contracts with Independent Practice Association and even more loosely affiliated networks.

- A substantial percentage of the market is self-insured or self-funded. However, systematic data on this portion of the market is not collected by the state and in not available from other public sources.

- Higher premiums than national averages. (See Figure 5.) There is, however, disagreement over whether and to what extent premiums in Massachusetts would still exceed national averages if adjustments were made for the higher cost of living in

[2] The term "reserves" is used in this document to mean reserves not committed to other obligations that are part of the company's business operations (e.g., it would not include specific reserves set aside to cover planned losses).

Massachusetts and any differences in comprehensiveness of benefits, and over whether some portion of the higher level of Massachusetts premiums reflects more intensive or elaborate patterns of care than may be prevalent in other regions of the country.

- Generally low profit margins among plans – though this is also reflective of trends nationally.[3] (See Figures 2, 7 and 8.)

- Low reserves at most health plans, compared with the size of the plans and reserve standards applied in other jurisdictions. (See Figures 9 and 10.)

- Low and decreasing rates of uninsurance, due largely to successful Medicaid expansion through the MassHealth program, to the strong economy, and to the continued and increased participation of employers in offering health insurance, and to the Qualified Student Health Insurance Program (QSHIP).[4] (See Table 2, Figures 11 and 12).

- Fewer explicit financial standards and requirements in certain areas, such as minimum capital and reserve requirements for HMOs and regulation of risk-bearing providers, than in some other jurisdictions.

- No clear statutory authority of the Insurance Commissioner in certain areas, such as review and approval of mergers and acquisitions and expansions into new market areas, as there is in some other jurisdictions. (See attached Summary of Current Laws and Regulations.)

Problems

Four major concerns have guided the working group's discussion of the financial condition of the four largest managed care plans: (1) the need for enhanced financial strength, through increased reserves and positive operating results; (2) discomfort with the disparity in premiums paid by small groups and individual enrollees compared with those paid by large groups; (3) a belief that premiums in general should be "affordable"; and (4) a belief that provider payments should be timely and adequate. These general concerns are in tension with each other, because an increased emphasis on any one of them may exacerbate problems involving one or more of the others. These main concerns, in variations, are woven throughout the report and are at the root of many of the problems listed below.

The working group identified the following issues during its discussions. This is neither an exhaustive list nor one that represents unanimity of opinion among working group members, but the group's discussion has focused on these matters.

[3] It has been reported that over half of the nation's 650 HMOs lost money over the past two years. See Jonathan R. Laing, "Investing in Health: Can Managed Care Be Saved?" (Barron's, May 15, 2000).
[4] QSHIP is a state mandate that requires all full and part-time college and graduate students (75% time or more) to carry health insurance. See 114.6 CMR 3.00.

- Although conditions differ among them, most of the Commonwealth's largest plans have had poor operating results in some or most of the last several years and as a result most have experienced a significant erosion in their overall financial condition.

- In recent months, the state's health plans have raised premiums significantly in order to improve their operating results. These premium increases may lead to increases in the number of Massachusetts residents without health insurance. Premiums are likely to rise again as financially troubled health plans attempt to improve their financial conditions and as providers seek higher payment levels. As premiums rise, it is possible that at least some employers will, at some point, be unwilling to pay higher rates, and may institute higher cost-sharing for their employees (e.g., higher premium contributions, increases in deductibles and copayments), reduce benefits, or drop coverage altogether. So far, it appears that most employers have absorbed most of the premium increases because of the strong employment market, but this could change if the economy weakens. Continued increases in premiums and a slow-down in the economy could lead to significant increases in the number of Massachusetts residents without health insurance.[5]

- Purchasers with less bargaining power may have to pay even higher premium increases, indirectly subsidizing purchasers that have more bargaining power. In general, small groups and individuals who purchase coverage directly (as opposed to through a larger group) pay higher premiums than larger groups. Some working group members believe that such disparities in premiums and premium increases relating to the size of the purchaser are unfair, and they question whether there should be more protection for smaller groups and individual purchasers through regulation or oversight of premiums. Other working group members believe that some premium disparities may be justified by the higher medical and administrative costs of smaller purchasers. Data on premium levels and profitability by line of business is still required to illuminate discussion of this issue, but plans do not currently provide this data to the Division of Insurance.

- Providers state that the payments they receive from plans do not, on average, cover their costs, and are made too slowly. In some cases, Medicare cuts implemented through the Balanced Budget Act may have eliminated the ability of some providers to cross-subsidize with Medicare dollars the payment rates they agreed to accept from private payers, thereby increasing pressure on plans to raise provider payments. Some hospital representatives have requested that the Commonwealth regulate payments from plans to providers, particularly to hospitals, to ensure that payment rates are adequate and that premium increases are shared equitably.

- Each of the four largest plans has so many enrollees that if any one of them were to be liquidated, the others would have considerable difficulty immediately assimilating

[5] See, for example, Milt Freudenheim, "HMO Costs Spur Employers to Shift Plans" (New York Times, September 6, 2000) and Liz Kowalczyk, "Health Coverage Costs Rising" (Boston Globe, September 15, 2000).

the enrollment of the liquidated plan, and the bargaining power of remaining plans with respect to providers could be enhanced (just as consolidation of providers has enhanced the bargaining power of some providers). This situation has led some working group members to question whether there is a sufficient number of health plans in the state, or whether there are some plans that have become "too big to fail." This problem may be more acute in some regions than in others.

Causes

The reasons for the financial condition of some of our health plans, and for some of the other problems identified above, vary from plan to plan. The following causes apply to one or more of the plans, to varying degrees:

- Recent history (1995-1999) of pricing premiums below the cost of delivering and administering covered services, in part to respond to employer demands for lower prices and in part because of strategic decisions by health plans to attempt to increase their market share. (See Figure 13.)

- Unsuccessful expansion into other geographic markets, where the premiums established by the health plans did not cover the cost of delivering and administering care in those markets, thereby depleting the reserves and resources of the Massachusetts-based plan.

- High and rapidly increasing medical costs in certain areas, notably pharmaceutical coverage.

- Information systems that have not consistently produced data accurately or quickly enough for management to evaluate and report the results of business operations in a timely fashion. Further, acquisitions and mergers may result in – and may have resulted in – delayed or inadequate integration (including systems, operations and cultures).

Among the reasons for provider payment rates that are regarded as too low by hospitals and other providers is hospitals' lack of success of many providers in bargaining for higher rates of payment in private negotiations. Prior to the Balanced Budget Act, hospitals may not have been as concerned about negotiating aggressively with HMOs because Medicare revenue made up for managed care losses. Hospitals may have been willing to give substantial discounts in order to attain greater volume or market share, particularly before plans included virtually all providers in their networks. In some cases, hospitals may have granted discounts to plans years ago when plans controlled a much smaller segment of the market, and may have had trouble increasing their payment rates as the plans' market share increased.

Inadequate information systems may have caused delays in accurate payment to some providers from some plans. As plans and providers upgrade their information systems, they will face significant additional administrative expenses.

Reasons for plan consolidation are similar to those that led to provider consolidation. As costs continued to rise and employers resisted substantial premium increases, plans and providers sought to strengthen their positions by acquiring larger market share and corresponding bargaining power and by gaining economies of scale. Achieving true integration of merged entities may not have been as important a business goal as consolidating market share. In addition, some Massachusetts plans developed business strategies that included expansion into other states in the context of potentially strong competition from national for-profit plans expanding into New England, and in order to match the regional geographic areas covered by larger employers. These Massachusetts plans may have felt that they needed to operate regionally in order to compete effectively.[6]

Differences in premium rates between small and large groups, even when they are purchasing similar products, are caused by some combination of (1) the fact that larger groups have greater bargaining power, and (2) the fact that claims experience is less predictable in small groups (although some working group members point out that this problem of "underwriting credibility" can be addressed through pooling a number of small groups together with a modest pooling premium). The Commonwealth does not require uniform pricing by insurers, managed care plans or providers. The state's small group law has limited the variation in small group rates by requiring that rates charged by a health plan to small group purchasers may vary by no more than a 2:1 ratio (i.e., a carrier or HMO may not charge any small group a premium that is more than twice the lowest premium it charges any other small group purchasing the same product). However, there is no limit to the level at which premiums may be set, no limit on the permissible variation among health plans, and no limit on the variation in premiums between small groups and large group purchasers.[7] (See Figures 14)

Reasons for high premiums in general relate to the high costs of care in Massachusetts – which in turn may be a result of a number of contributing factors, including relatively greater reliance on teaching hospitals, high numbers of physicians, particularly specialists, and utilization rates that are higher than those observed in other locations. Some group members believe that certain Massachusetts mandated benefits that are expensive to provide, such as infertility services and Autologous Bone Marrow Transplants for women with metastatic breast cancer, may also be responsible for some of the high cost of Massachusetts premiums. Others have questioned whether it is possible to isolate the marginal cost associated with particular mandated benefit requirements, because in many cases plans might have included the benefit even without the mandate. Data about the additional premium cost associated with particular mandated benefits in Massachusetts has been difficult to find. (See Tables 3, 4 and 5.)

[6] See Joy Grossman, "Health Plan Competition in Local Markets," Health Services Research, Vol. 35 No.1 April 2000, pp. 17-35.

[7] Qualified small employers and their qualified employees may receive subsidies for premiums through the Insurance Partnership program, part of the MassHealth program.

Strategies and Options

Some strategies for addressing the problems our plans – and other parts of our health care system – are experiencing would fundamentally change the Massachusetts health care financing and delivery systems. Those strategies, including adoption of a single payer system, development of new programs such as rate setting, new ways of purchasing health insurance, and the like, are possible long-term solutions and are being considered by a different group.[8] For the most part, the working group has confined its discussions to short-term or intermediate-term interventions. These interventions, along with associated advantages and disadvantages, are grouped loosely under headings corresponding to the main problems identified above – though clearly some of the strategies discussed could appear under multiple headings.

The Need for Enhanced Financial Oversight

Increase Premiums. The most obvious way for a plan to improve its financial condition is for it to charge higher premiums (i.e., premiums that are more than adequate to cover expenses, thereby generating positive net income) and to use the increased revenue to build its reserves and strengthen its financial position. In fact, health plans have substantially increased premiums this year, along with most other insurers. On the other hand, Massachusetts already has high premiums, and further significant increases could lead employers to leave the state or choose not to locate here. Employers who stay may limit their financial contributions to insurance coverage, shifting much of the burden of higher health insurance premiums to employees. More employers may choose to self-insure, offering benefit plans that are subject only to federal regulation under ERISA. Alternatively, employers or employees may choose to forgo health insurance if their share of premiums rises dramatically, leading to an increase in the number of people without health insurance. (See Figures 15, 16 and 17.)

Health plans and other insurers are in the center of pressures permeating the health care world. Employers want premiums kept as low as possible, enrollees are sensitive to increases in copayments and co-insurance amounts, and providers are seeking higher rates of payment from health plans. In addition, insurers are competing with one another to please each of these constituencies in order to maintain or enhance their enrollment, financial strength and competitive position. At the same time, some enrollees (and often employers) are seeking to avoid traditional cost-containment mechanisms such as medical management and limited provider networks. Due to the confluence of these many forces on health plans and their premium structures, it seems unlikely that premium increases alone will suffice to stabilize the system over time and, in fact, continued substantial increases could be a destabilizing factor.

[8] Section 32 of Chapter 141 of the Acts of 2000 establishes an advisory committee to arrange for and evaluate an independent analysis of the feasibility and fiscal implications of establishing a system of consolidated health care financing and delivery. The relationship between that advisory committee and the Health Care Task Force with respect to these issues remains to be clarified.

Enact minimum net worth and reserve requirements. These substantive financial requirements have been enacted in many other states and are recommended by the National Association of Insurance Commissioners. The Governor filed legislation earlier this year that includes these requirements. Enacting these requirements, some of which would be phased in over time, would ensure that health plans would be required to maintain a higher minimum level of reserves than most currently have, and that they would therefore be in a better position to withstand market fluctuations and unforeseen events.

Enact statutory authority for the Insurance Commissioner to oversee major transactions. The Insurance Commissioner has indicated that she does not have the authority to review certain fundamental transactions of health plans. Such authority could have enabled the Commissioner to investigate and raise questions or highlight problems in connection with certain mergers and expansions into other states that have led to problems for some of the plans. Such specific oversight authority may help, but it will not alone prevent all bad outcomes.

Enact legislation requiring more detailed and frequent reporting. Requiring reports showing financial data and performance by line of business (e.g., separating data on small group, Medicare, large group, etc.) would help the Division of Insurance (and perhaps the plan's own managers) to anticipate certain financial problems that could result if some lines of business are subsidizing others. In addition, financial and enrollment information on the plan's "administrative services only" (or ASO) business, in which the HMO administers a self-funded ERISA plan on behalf of an employer, would help the Division monitor market dynamics and evaluate reserve needs. One disadvantage to this approach is that reports filed with the Division of Insurance are public documents. If plans felt such increased reporting would hamper their ability to compete, confidentiality protections could be considered, although some working group members believe this type of data should be public. Also, any particular new reporting requirement should be tailored as narrowly as possible to achieve its desired goal, and should be evaluated in light of the estimated administrative costs associated with it.

Require HMOs to file financial reports using both statutory accounting and Generally Accepted Accounting Principles (GAAP). Statutory accounting rules are more conservative than GAAP rules with respect to valuing non-liquid assets. In general, insurance regulators use statutory accounting because it provides a more conservative view of a company's financial condition. Massachusetts currently requires all non-HMO insurers to file financial reports using statutory accounting, and requires HMOs to submit audited financial statements using GAAP accounting. Although HMOs are also filing financial statements using statutory accounting, the Insurance Commissioner has indicated that her authority to compel such filings is unclear. Legislation that would require HMOs to submit reports using statutory accounting has been filed for a number of years and is currently pending before the General Court. While some people have commented that this requirement will increase administrative expenses of HMOs, others have doubted that administrative costs would increase substantially as a result of this requirement.

Require that premium rates be certified by an independent actuary as "actuarially sound" This requirement, in theory, would increase the likelihood that plans will set premiums at a level that will cover the cost of providing benefits. The group has heard descriptions of the so-called actuarial cycle in which insurers cut premiums below the level required to support their product in years in which the insurer has resources to absorb losses, as a way of gaining market share. In succeeding years when reserves are depleted, rates are raised to cover costs of care and to build reserves. There are several different approaches to ensuring that rates are actuarially sound, ranging from requiring an independent actuary to certify that sample rates and methodologies used to establish rates are actuarially sound (which would not prevent plans from discounting rates for particular contracts), to requiring that most or all rates actually used be certified as actuarially sound (which would be burdensome, expensive and potentially unworkable). Working group members are not in agreement about which type of approach is better, but generally agree that options for decreasing the fluctuations in plan financial condition caused by the actuarial cycle should be further explored.

Explore increasing general oversight of health care nonprofits. Some working group members have raised for future discussion the general question whether the state should pursue further oversight, including possible increased authority to oversee, health care public charities, including boards of trustees, through the Attorney General.[9]

Disparity in Premiums

Directly Regulate or Approve Actual Premiums. Currently, Massachusetts requires HMOs and other insurers to file general premium "base" rates, but does not require that the Commissioner review or approve actual rates before they are put into place. While requiring prior approval would in theory give the Commissioner the authority to require that premiums be set in a manner that is "fair," working group members do not agree on how such "fairness" would be measured. Is it more appropriate to require that a particular group's premiums be sufficient to cover the estimated costs of caring for that group's enrollees (which could perpetuate disparities in rates paid by large and small purchasers)? Should there be explicit subsidies of some groups by others? In addition, some group members feel that instituting such regulation could dissuade national insurers from participating in the Massachusetts market and could lead employers to self-insure in order to avoid state regulation. This in turn would narrow the insurance market and shrink the population of enrollees among which HMOs and insurers could spread risk – leading to premium increases for those remaining in the insurance market.

Increase protections for small groups and non-group enrollees. Massachusetts already regulates premiums in these two markets. As noted above, rates for small groups buying the same product from the same carrier in the same geographic area may not vary by more than a factor of two (i.e., the highest rated group pays no more than twice the rate for the lowest rated group, for the same product offered by the same plan). This standard

[9] Several working group members have noted the increasing responsibility, and potential liability, of directors of nonprofit organizations engaged in health care activities.

is common among other states. Massachusetts alone requires that a carrier offering small group insurance must also offer a nongroup product. If a carrier wishes to charge a nongroup rate that is more than two standard deviations above the average nongroup rate for the type of product, the Division of Insurance must hold a public hearing on the rate. This standard does not prevent large variations in premiums for similar products. None of these standards addresses disparities between premiums paid in the small and nongroup markets and those paid by large employers. Some working group members have suggested that the best way to protect small group and nongroup purchasers from unreasonable premiums is to oversee more directly the premiums charged in those markets to ensure that they are fair and reasonable. The group has not reviewed specific proposals for such intervention.[10] Other group members feel that the fundamental problem of disparity in premium rates cannot be addressed without examining and possibly adjusting the premiums paid by large employer groups. As outlined above, this approach carries the risk that large employers will self-insure or leave Massachusetts altogether.

Affordability of Premiums

Strategies for making premiums generally more affordable center on reducing administrative costs of health plans or controlling underlying costs of care. Although the working group discussed the importance of reducing administrative costs and developing strategies to improve quality as ways of addressing underlying health care costs, it has not discussed specific strategies in these areas, which other groups are discussing. Fundamental system reform, such as adopting a single payer health care system, could also address underlying costs, but is beyond the scope of the working group's analysis to date.

Adequacy of Provider Payment

Increase oversight of risk contracts and risk-bearing providers. Currently, Massachusetts does not require that providers accepting substantial financial risk comply with requirements that apply to insurance companies. The newly enacted managed care legislation requires that managed care company risk contracts with physicians and physician groups address (1) stop-less protection, (2) minimum patient population size for the physician or group assuming risk, and (3) identification of the services for which the physician or group is at risk. Other states have taken a more aggressive approach to regulating risk-bearing providers. Increased oversight could take several forms, from requiring managed care organizations to report on organizations with which they maintain risk contracts, to regulating risk-bearing providers directly. Group members believe that oversight of risk arrangements should be tailored to ensure (1) that the provider or group assuming risk has the financial resources and operational capability to manage that risk, and (2) that the financial arrangement is reasonable. In Massachusetts, some providers have dropped out of risk arrangements such as Medicare risk products,

[10] One group member has suggested that an option to be explored would be to require that average premiums in the small group and nongroup markets not exceed average premiums paid by large employers by more than a stipulated percentage. This and other proposals should be evaluated further.

and others have said that they want to move away from risk assumption. In other states, such as California and New Jersey, widely publicized financial troubles of providers who assumed risk and then became insolvent, leaving unpaid claims, have led to heightened state oversight of risk contracting as a means of protecting consumers and providers. While these arrangements were meant to place the insurance and provider functions in one entity in part to control health care costs, the experience to date suggests that most providers have difficulty managing the insurance function.

Regulate provider rates. Some providers have suggested that the state should regulate the amount of provider payments made by health plans and other insurers to ensure that providers are compensated for the cost of the care they provide. This proposal appears to entail a general rate-setting approach. Massachusetts turned away from a rate setting that did not apply to all payers in the early 1990s for a variety of technical, fiscal and (some would say) political reasons. Regardless of their particular reasons, payers and providers generally agreed that that system did not work well. Rate setting would probably ensure the survival of distressed providers, but could increase premium levels, depending on the level at which rates would be set. While the group is concerned that provider payments be adequate and timely, members do not agree on whether rate-setting is an appropriate means to achieving that goal.

Create an insolvency fund for health plans. Such an insolvency fund would be created through a system of assessments on health plans, and possibly other insurers, in the event a plan becomes insolvent and is liquidated. The funds collected through assessments would be used to pay unpaid claims left by the insolvent plan. This approach would provide more security to providers with respect to outstanding receivables from HMOs, but would meet with substantial resistance from health plans and other insurers that would be assessed. For the foreseeable future it seems unlikely that HMOs alone could adequately fund such an insolvency fund.

Recommendation

The working group has reached consensus on a number of strategies focused on financial stability. In general, the Division of Insurance would benefit from increased and clarified statutory authority giving it "tools" to use in helping HMOs maintain and improve their financial position and in protecting consumers, and would benefit as well from additional resources devoted to health oversight (which the Legislature has begun to address in the most recent supplemental budget). In general, laws and regulations governing HMOs should include strong, reasonable standards for financial soundness, adequate authority for the Commissioner to intervene – publicly or confidentially – where there are signs of trouble, and adequate protection for consumers in the event of insolvency (addressed late last year). Where new legislative requirements are necessary to complete this scheme, they should be developed with caution and with attention to the cost any new regulatory measure is likely to bring (to be paid, ultimately, by consumers) and to how any new measure will fit with existing requirements. Given the number of new requirements imposed under recent legislation, the group recommends that the Commonwealth review and where necessary streamline administrative and reporting requirements. While the

group has not drafted and does not intend to draft proposed legislation, it is prepared to make the following preliminary and general recommendations:

- Enact legislation establishing minimum net worth and risk-based capital requirements, consistent with national standards (discussed on page 7 above).

- Require that plans report financial results by line of business, that they file reports using statutory accounting rules as well as GAAP, and that they report on "ASO" business and enrollment (discussed on page 8 above).

- Explore approaches to increasing oversight of risk-sharing arrangements and risk-assuming providers to ensure that providers have the operational capability and financial resources to manage the risk assumed and that the financial terms of the arrangement are reasonable. Although recently enacted legislation begins to address this issue by requiring that risk contracts with physicians address stop-loss arrangements and other protections, further oversight could be indicated, and regulatory models from other states should be evaluated (discussed on page 10 above).

- Require that new mandates, including mandated benefits and reporting requirements, be considered in the context of the likely premium increases they will cause (discussed on page 8 above).

- Enact legislation giving the Insurance Commissioner authority to oversee certain fundamental transactions of HMOs, such as sales of substantial assets, mergers, and expansion into other states (discussed on page 7 above).

- Explore further the possibility of requiring that premiums be certified as actuarially sound by an independent analyst (discussed on page 8 above).

Summary of Current Laws and Regulations

Licensure and Re-Licensure -

Section 22 of Chapter 141 of the Acts of 2000 requires that each HMO applicant for licensure or licensure renewal (annually) shall submit to the commissioner for his approval (and to the office of patient protection in the department of public health) such materials as the commissioner shall by regulation require, in a form approved by the commissioner. Said materials include but are not be limited to: (1) a copy of the basic organization document; (2) a copy of the by-laws, rules and regulations, or similar; (3) a statement generally describing the health maintenance organization, its health care plan or plans, facilities and personnel; (4) an internal operations plan; (5) a provider inventory; (6) a copy of contract forms, administrative contracts, and written procedures and standards for the prior review and approval by the applicant of provider subcontracts; (7) a copy of the form of evidence of coverage to be issued to the members; (8) a copy of the form of group contract, if any, which is to be issued to employers, unions, trustees, or other organizations; (9) financial statements showing the applicant's assets, liabilities, and sources of working capital and other sources of financial support and projections of the results of operations for the succeeding three years; (10) a financial plan, including a statement indicating when the applicant estimates that income from operations will equal expenses, a statement of the applicant's plan to establish and maintain sufficient reserves to cover projected risks, copies of reinsurance or other agreements to provide for provision of contracted health services in the event the applicant is unable to provide such services for any reason, and a detailed description of mechanisms to monitor the financial solvency of any organization contraction [sic] with the applicant that assumes substantial financial risk for the provision of health services; (11) a plan for compliance with section 15, including copies of any contract or agreement with a carrier for reinsurance; (12) an enrollment and marketing plan for health services delivered in the organization's service area; (13) a utilization plan; (14) premium rates for all products offered; (15) a member services plan; (16) a detailed description of the quality assurance system; (17) a detailed description of the formal internal grievance; and (18) evidence of compliance with chapter 176O. Any applicant accredited by the managed care bureau established under section 2 of chapter 176O shall be deemed to meet the requirements of this chapter with respect to requirements with any utilization review standards.

211 CMR 43.05 requires HMOs to file (1) unaudited financial report within 60 days of close of fiscal year, as specified by NAIC and (2) audited financials (per Generally Accepted Accounting Principles) within 120 days of close of preceding fiscal year. (Massachusetts statutes do not expressly authorize the use of statutory accounting principles in this field.)

Minimum Capital and Surplus -

No explicit statutory provision under MA law. Per 211 CMR 43.04, HMO must demonstrate upon initial licensing that it has sufficient financial reserves to meet its financial obligations.

Reserves –

No statutory provision under MA law. Per 211 CMR 43.04, HMO must demonstrate upon initial licensing that it has sufficient financial reserves to meet its financial obligations.

Deposits with State Treasurer –

A "deposit – like" requirement is imposed via c. 176G, section 15 (see also 211 CMR 43.04): "evidence of a surety bond or deposit satisfactory to the commissioner in at least the same amount as a guarantee that the obligation to the enrollees will be performed."

Risk – Based Capital Filing -

No statutory or regulatory provision under MA law.

Financial Examination of HMO's –

Chapter 176G, section 10 requires that the "commissioner make an examination of the affairs" of an HMO "when he deems prudent, but in any event not less frequently than once every two years". The records of the examination shall be confidential but the final report "shall be a public record."

Administrative Supervision and Receivership Duties -

As noted above, the Division of Insurance has the duties of administrative supervision and receivership as set forth in M.G.L. chapter 175J and Chapter 143 of the Acts and Resolves of 1999 as directed to the licensees otherwise under its statutory purview.

The November 24, 1999 law signed by Governor Cellucci explicitly required the subject entities to bear the cost of such administrative supervision: "The commissioner may employ staff personnel and outside counsel and other consultants as may be necessary for the proper conduct of the administrative supervision. All reasonable costs of such outside counsel and other consultants, including the costs attributable to the use of staff personnel, shall be borne by the insurer under administrative supervision."

Administrative supervision may be ordered if the financial condition "renders the continuance of its business hazardous as defined in subsection C to its policyholders or the general public." The statute specifies a set of standards to determine whether the instant financial condition presents such a hazard. See Chapter 175J, section 3C, as amended by Chapter 143 of the Acts and Resolves of 1999. These standards include but are not limited to material adverse findings as reported in examination reports, NAIC IRIS reports, ratios of expense, policy benefits and reserve increases to premium and investment income which "could lead to an impairment of capital and surplus", inability

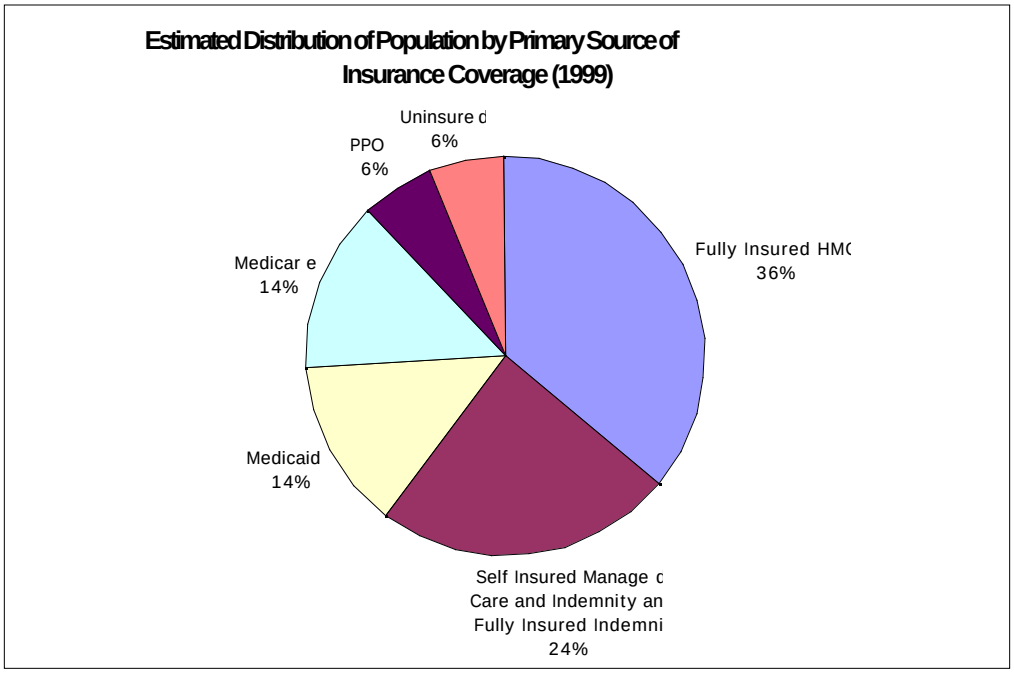
to have financial or administrative capacity to meet obligations in a timely manner, or future cash flow or liquidity problems.

Section 6 of Chapter 175J details the confidentiality procedures applicable in an administrative supervision context. The Commissioner may open the record if she "deems that it is in the best interest of the public or in the best interests of the insurer, its insureds, creditors or the general public." See Chapter 175J, section 6D.

In addition, the November 24, 1999 law added a detailed set of conditions allowing the Commissioner – as represented by the Attorney General or Special Assistant Attorneys General so designated - to specifically trigger a receivership proceeding against the listed licensees. In addition to the significant protections afforded within section 21 of this law, it also provided that "in the event of the insolvency of a health maintenance organization: (1) a member of a health maintenance organization shall not be liable to any health care provider for any covered health services provided to the member, except as provided in subsection (c); (2) a health care provider or any representative of a health care provider may not collect or attempt to collect from a member money owed to the health care provider by a health maintenance organization; (3) a health care provider or any representative of a health care provider may not maintain any action against a member to collect or attempt to collect any money owed to the health care provider by a health maintenance organization. (c) Notwithstanding any other provision of this section, a health care provider or representative of a health care provider may collect or attempt to collect from a member: (1) a co-payment, deductible, or co-insurance amounts owed by the member to the health care provider for covered services provided by the health care provider, or (2) a payment or charges for services not covered under the member's health maintenance contract."

Confidentiality procedures in receivership are subject to appropriate court order as was seen in the Harvard Pilgrim context.

Figure 1:



Source: Massachusetts Division of Insurance, Massachusetts Division of Health Care Finance and Policy, Massachusetts Division of Medical Assistance, Health Care Financing Administration

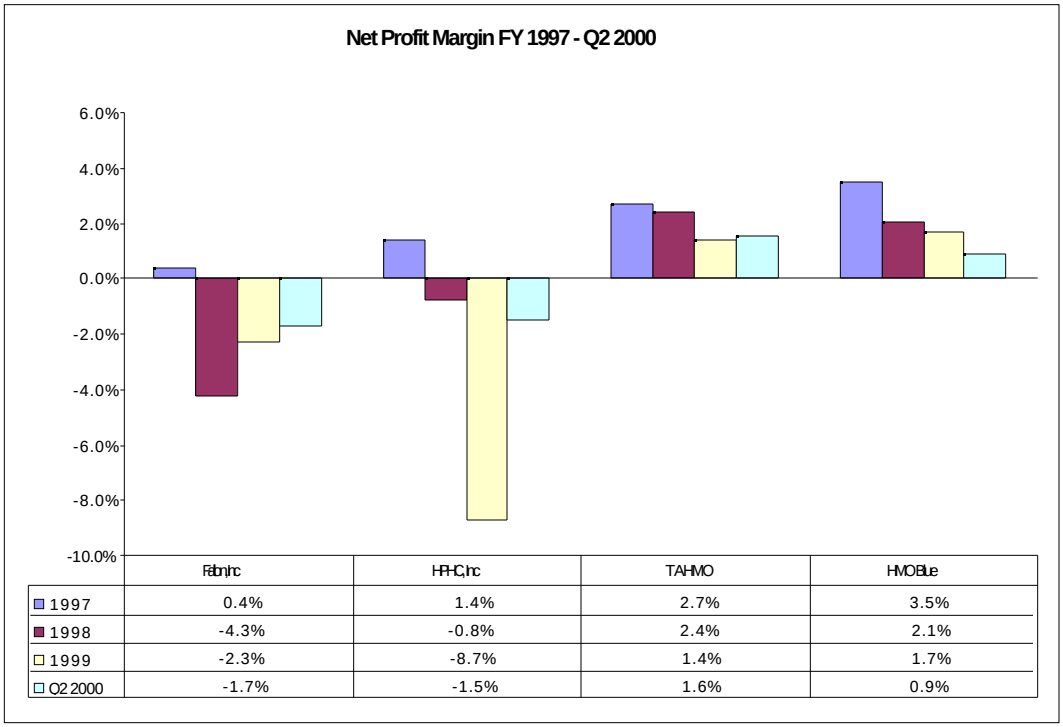
Note: To our knowledge, data is not collected on self-insured or indemnity enrollees, therefore these numbers were estimated by subtracting the other segments of the market from the state's total population. This is a very rough estimate and should not be relied upon for policymaking purposes.

Table 1:

Health Plan Type	Insured Non-ERISA Plan	Insured ERISA Plan	Self-Funded ERISA Plan
Examples of Health Plans	* Individual policies * Supplemental policies	* Single employer plans * Plans formed pursuant to collective bargaining agreements	* Single employer plans * Plans formed pursuant to collective bargaining agreements
Statutory/Regulatory Authority over Administration	* State law * Departments of Insurance (DOI) (or appropriate regulatory agency)	* Federal law * Department of Labor (DOL) * Limited Authority by DOIs	* Federal law * Department of Labor (DOL)
Statutory/Regulatory Authority over Solvency	* State law * DOIs	* State law * DOIs	* Federal law * Department of Labor (DOL)

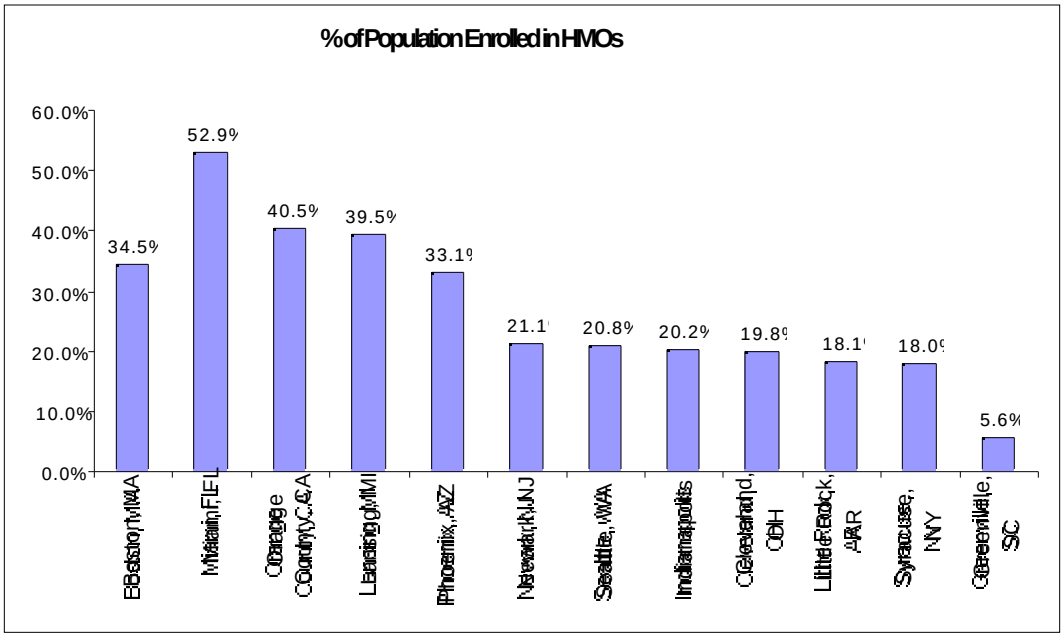
Source: "1994 NAIC WHITE PAPER: ERISA: A CALL FOR REFORM RECOMMENDATIONS OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS"

Figure 2:



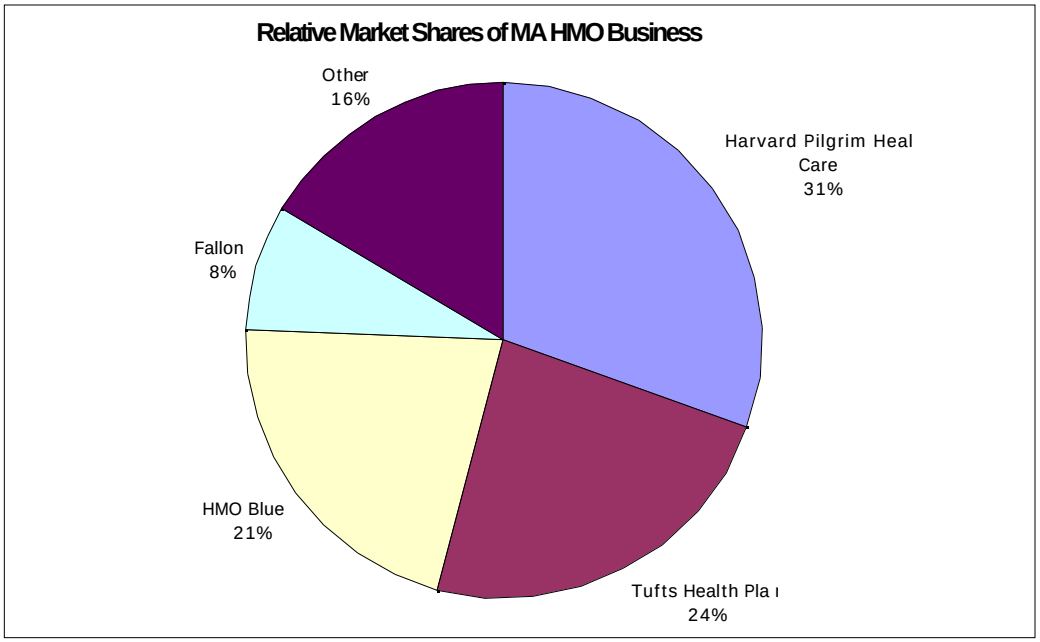
Source: Massachusetts Division of Insurance

Figure 3:



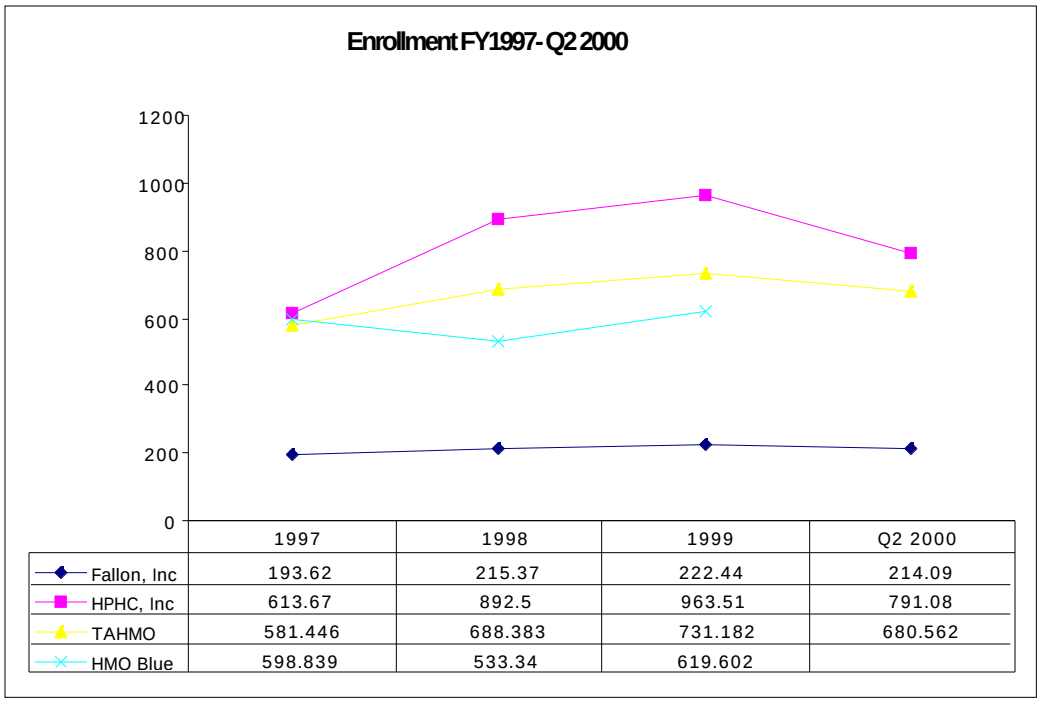
Source: Community Tracking Study, presented in *Health Services Research*, April 2000.

Figure 4:



Source: Massachusetts Division of Insurance, membership data as of December 31, 1999.

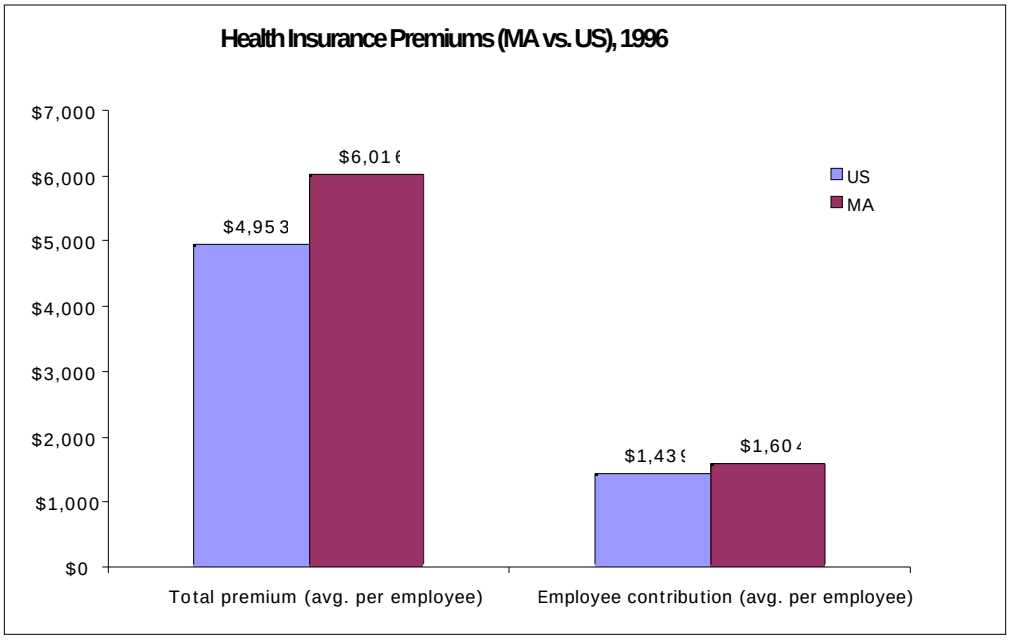
Figure 5:



	1997	1998	1999	Q2 2000
Fallon, Inc	193.62	215.37	222.44	214.09
HPHC, Inc	613.67	892.5	963.51	791.08
TAHMO	581.446	688.383	731.182	680.562
HMO Blue	598.839	533.34	619.602	

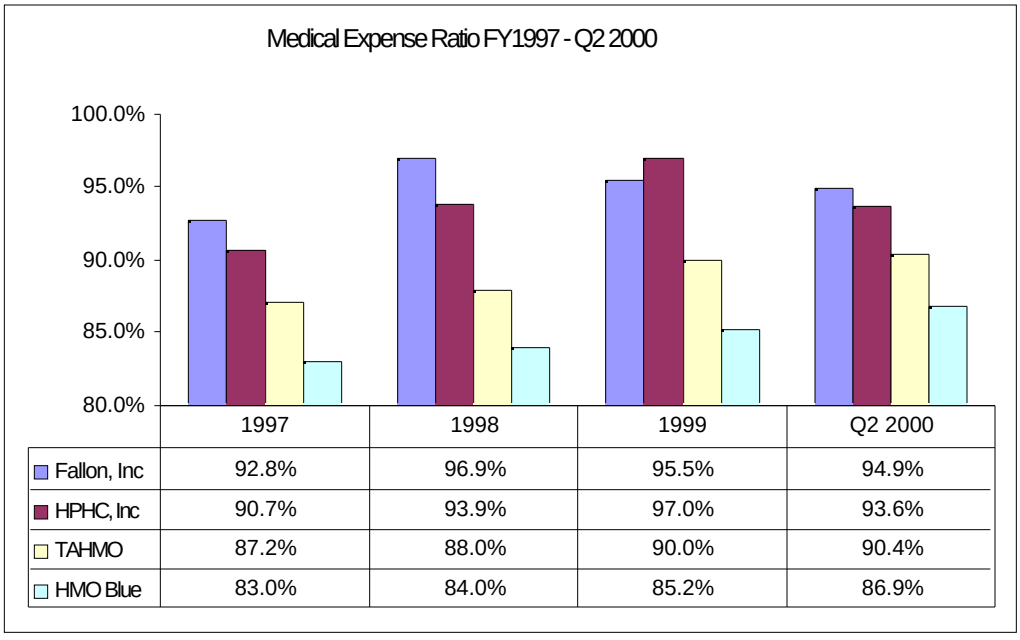
Source: Massachusetts Division of Insurance
Note: Enrollment numbers were taken from NAIC Membership Reports and as a result may include out-of-state members and Preferred Provider Plan members for some of the HMOs.

Figure 6:



Source: *Reforming the Health Care System: State Profiles 1999,* AARP 1999

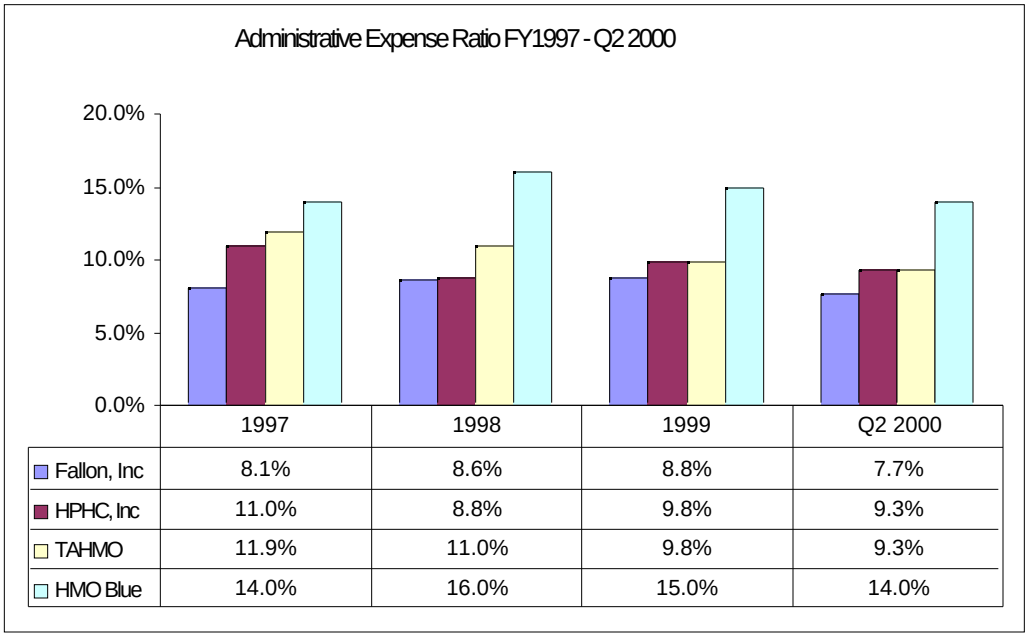
Figure 7:



	1997	1998	1999	Q2 2000
Fallon, Inc	92.8%	96.9%	95.5%	94.9%
HPHC, Inc	90.7%	93.9%	97.0%	93.6%
TAHMO	87.2%	88.0%	90.0%	90.4%
HMO Blue	83.0%	84.0%	85.2%	86.9%

Source: Massachusetts Division of Insurance
Notes: 1. The numbers presented for HPHC, Inc do not represent the merged Harvard Pilgrim Plan.
2. All data presented for Q2 2000 are based on unaudited financial data.
3. For FY1997 and FY1998, the HPHC, Inc data do not include liabilities identified in review of FY1999 reports.
4. HPHC, Inc. data for FY1999 - Q2 2000 are based on statutory accounting while all other data are based on GAAP accounting.

Figure 8:



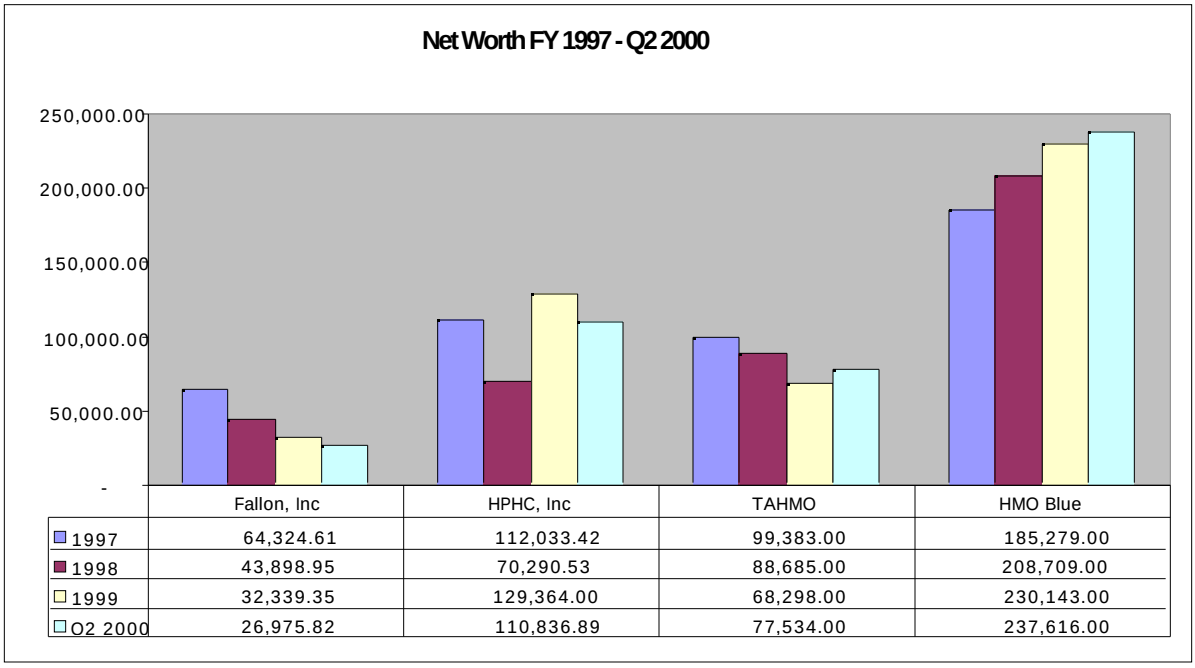
	1997	1998	1999	Q2 2000
Fallon, Inc	8.1%	8.6%	8.8%	7.7%
HPHC, Inc	11.0%	8.8%	9.8%	9.3%
TAHMO	11.9%	11.0%	9.8%	9.3%
HMO Blue	14.0%	16.0%	15.0%	14.0%

Source: Massachusetts Division of Insurance
Note: See Notes for Figure 7.

Figure 9:

(Reserved)

Figure 10:



	Fallon, Inc	HPHC, Inc	TAHMO	HMO Blue
1997	64,324.61	112,033.42	99,383.00	185,279.00
1998	43,898.95	70,290.53	88,685.00	208,709.00
1999	32,339.35	129,364.00	68,298.00	230,143.00
Q2 2000	26,975.82	110,836.89	77,534.00	237,616.00

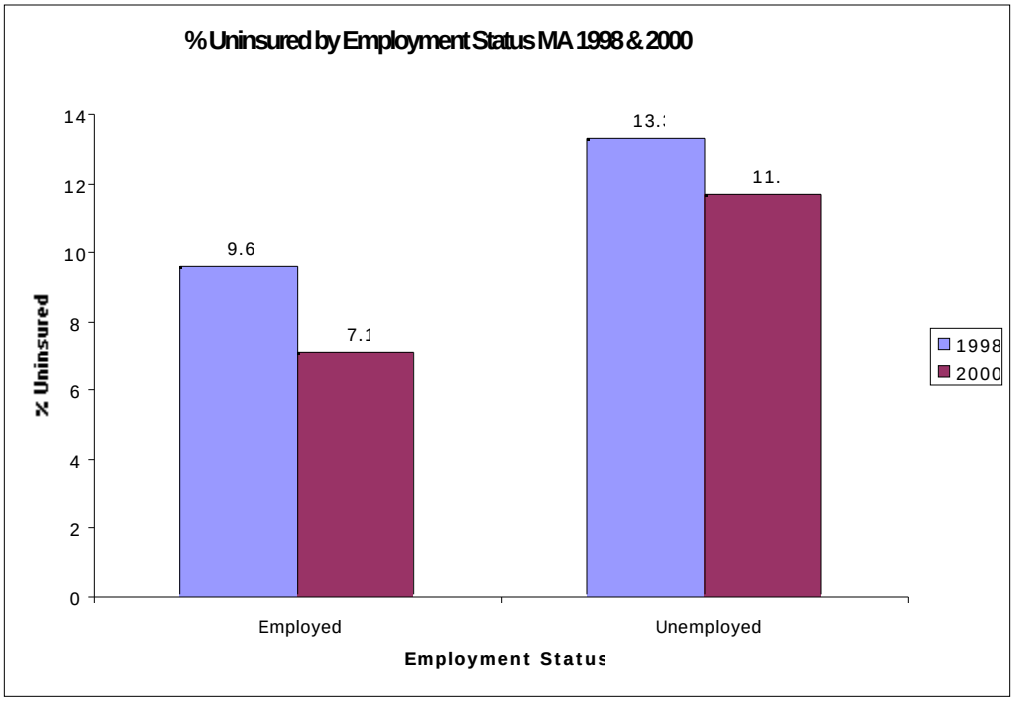
Source: Massachusetts Division of Insurance
Note: See Notes for Figure 7.

Table 2:

Massachusetts Rates of Uninsurance, 1998 vs. 2000		
	1998	**2000**
All Ages	8.2%	5.9%
Under 65	9.3%	6.5%
18-64	10.8%	8.0%
Under 18	5.8%	2.8%

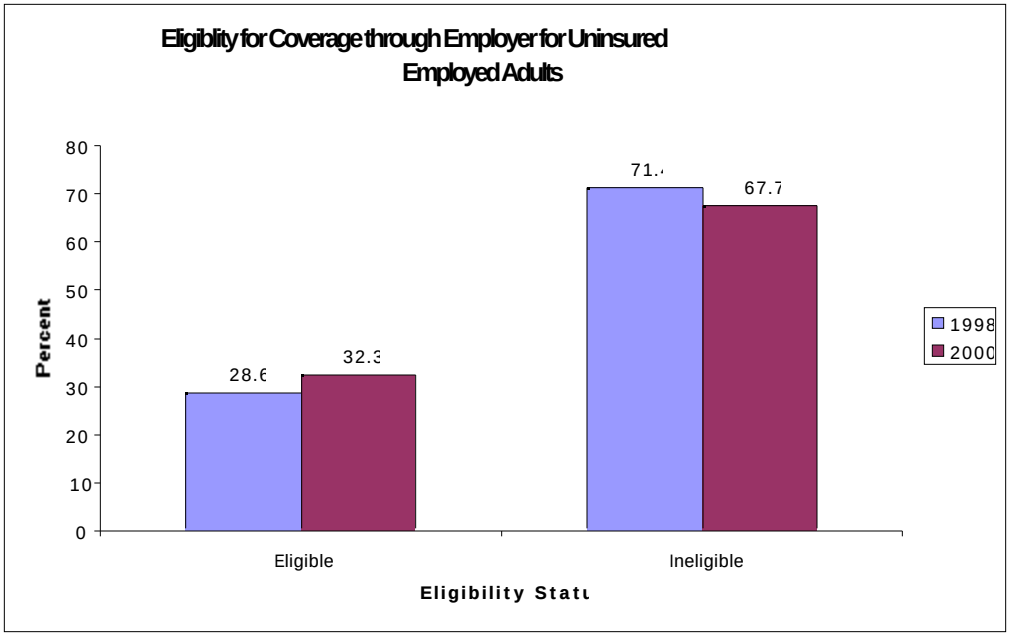
Source: Massachusetts Division of Health Care Finance and Policy

Figure 11:



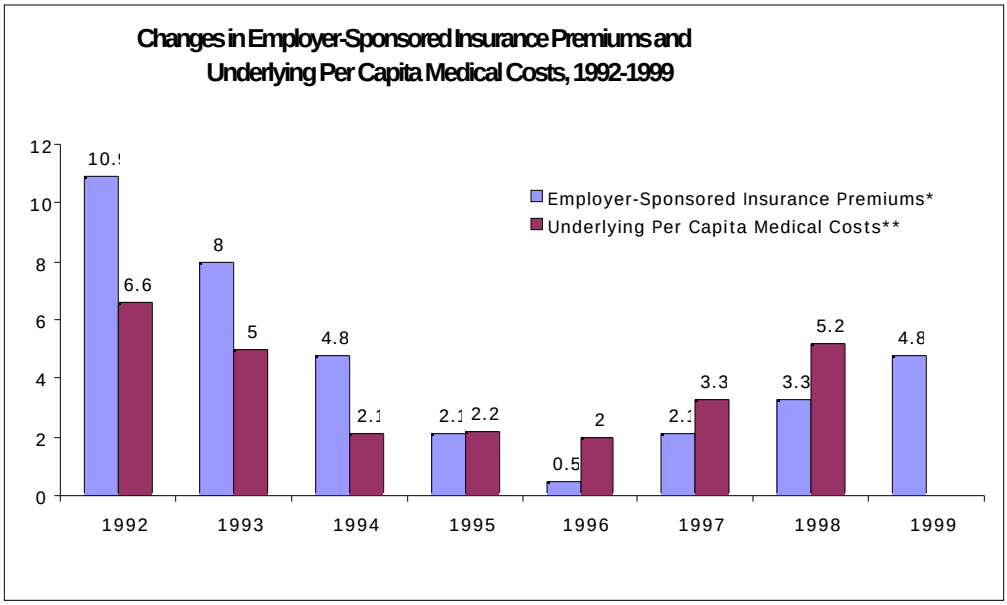
Source: Massachusetts Division of Health Care Finance and Policy

Figure 12:



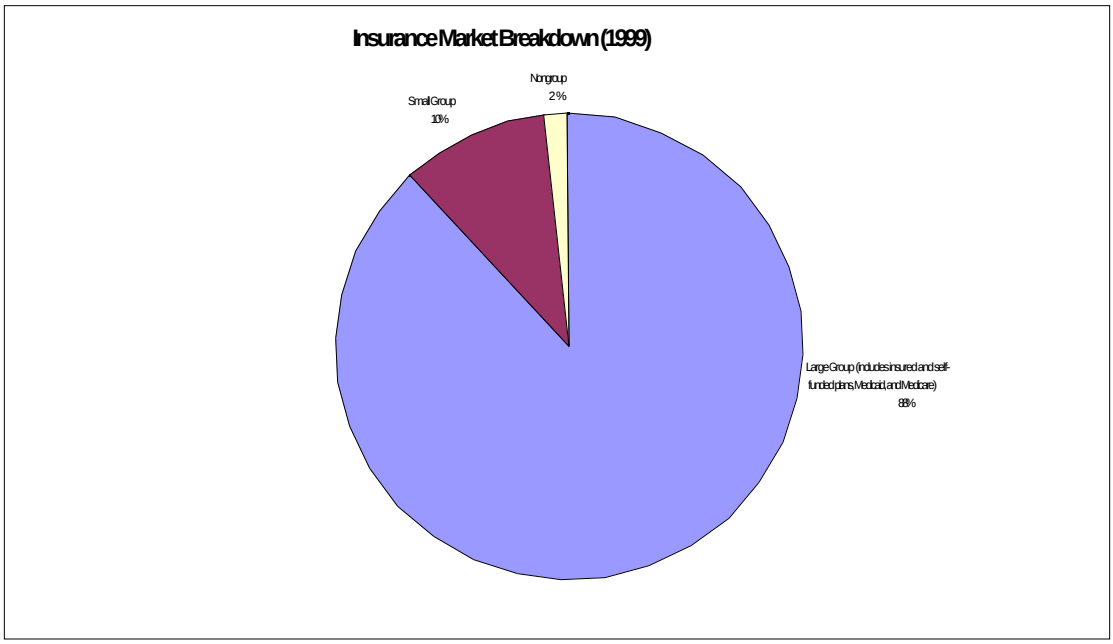
Source: Massachusetts Division of Health Care Finance and Policy

Figure 13:



*KFF/HRET Survey of Employer-Based Health Plans (1999) and KPMG Peat Marwick Survey of Employer-Sponsored Health Benefits (1992-1998).
**Milliman & Robertson, Health Cost Index, $0 deductible. Data are not expanded to include Medicare.
Note: 1999 Cost Index not available.

Figure 14:



Source: Massachusetts Division of Insurance, Massachusetts Division of Health Care Finance and Policy

Mandated Benefits

Mandated benefits require insurers (excluding self-insured plans) to provide coverage for particular services or providers. Historically, the most common mandates required coverage for specific providers, preventive treatments—i.e., cancer screenings—and for treatment for mental health and alcohol and substance abuse. However, the more recently enacted mandates generally require coverage for specific disorders, diseases, procedures, and drugs and supplies. Mandates vary significantly in cost. The rankings shown in the tables below do not necessarily imply that the state with the most mandates also has the highest premium cost associated with those mandates. Some mandates, such as obstetrics and mental health, may be very expensive, whereas others may add very little cost depending on their utilization and actual cost (such as certain provider mandates and hair prosthesis.) Therefore, a state could have a higher number of mandates, yet have a lower total cost associated with those mandates because they are less expensive. Furthermore, Even though two states may seem to have the same mandate, coverage provisions might vary, thus potentially making the cost of a particular mandate different in each state. An example of this is infertility coverage in Massachusetts and Maryland; in Maryland the benefit is only for in vitro fertilization under certain conditions and the law excludes HMO plans and small groups from having to comply, while the Massachusetts benefit covers a list of six infertility treatments and applies to all insurers.

Unfortunately, studies on the financial impact of mandating benefits are limited. However, Maryland has completed a financial analysis of its mandates, which, if done for Massachusetts, might be worthwhile. Additionally, to our knowledge, no states have completed a study on the money saved by covering cancer screenings (which can catch cancer early before expensive treatments are needed) and benefits such as contraceptives (which saves high obstetrics costs).

Regarding the mandated benefits tables provided, the following definitions apply:

- *Persons Covered:* The different types of dependents of the insured required to be covered, as well as continuation of coverage for dependents, employees and conversion to non-group. For example, adopted children, newborns (for whom all states require coverage), dependent students, etc.
- *Benefits Covered:* Specific diseases, disorders, procedures, prescription drugs, screenings, devices, etc., which states require to be covered.
- *Providers Covered:* Services provided by specific types of providers that are required to be covered, e.g. chiropractors, dentists, naturopaths, nurse practitioners, optometrists, physical therapists, etc.

Note: Mandated offerings, in which insurers are required to offer a particular benefit to purchasers but purchasers may choose not to purchase the benefit, are not included in these tables. These tables include those mandates enacted through the 1999 legislative year. Depending on the state, mandate laws apply to various types of health coverage (individual, small group, large group, HMO, PPO, "health plans", "health insurers", etc). Therefore, even if two states have similar benefit language in their statutes, one might exempt a specific group from compliance (for example, "HMO enrollees"). Also, a few mandate laws do not apply to Blue Cross and Blue Shield plans (although this is not the case in Massachusetts). This information is not reflected in the tables for simplicity's sake.

Table 3:

Mandated Benefits: Benefits Covered		
Ranked by State from Most to Least		
RANK	***STATE***	***NUMBER OF BENEFITS***
1	Maryland	26
2	Connecticut	21
2	Minnesota	21
4	California	17
4	Virginia	17
4	Rhode Island	17
7	Florida	16
7	**Massachusetts**	**16**
7	New Jersey	16
7	Texas	16

Source: Blue Cross and Blue Shield Association, December 1999.

Table 4:

Mandated Benefits: Providers Covered Ranked by State from Most to Least		
RANK	***STATE***	***NUMBER OF PROVIDERS COVERED***
1	Utah	19
2	Wyoming	17
3	Florida	16
3	Maryland	16
5	Texas	15
6	Minnesota	14
6	Virginia	14
8	California	13
8	Montana	13
8	Pennsylvania	13
11	Connecticut	12
12	North Carolina	11
12	Nevada	11
14	**Massachusetts**	**10**
14	Michigan	10
14	New Mexico	10

Source: Blue Cross and Blue Shield Association, December 1999.

Table 5:

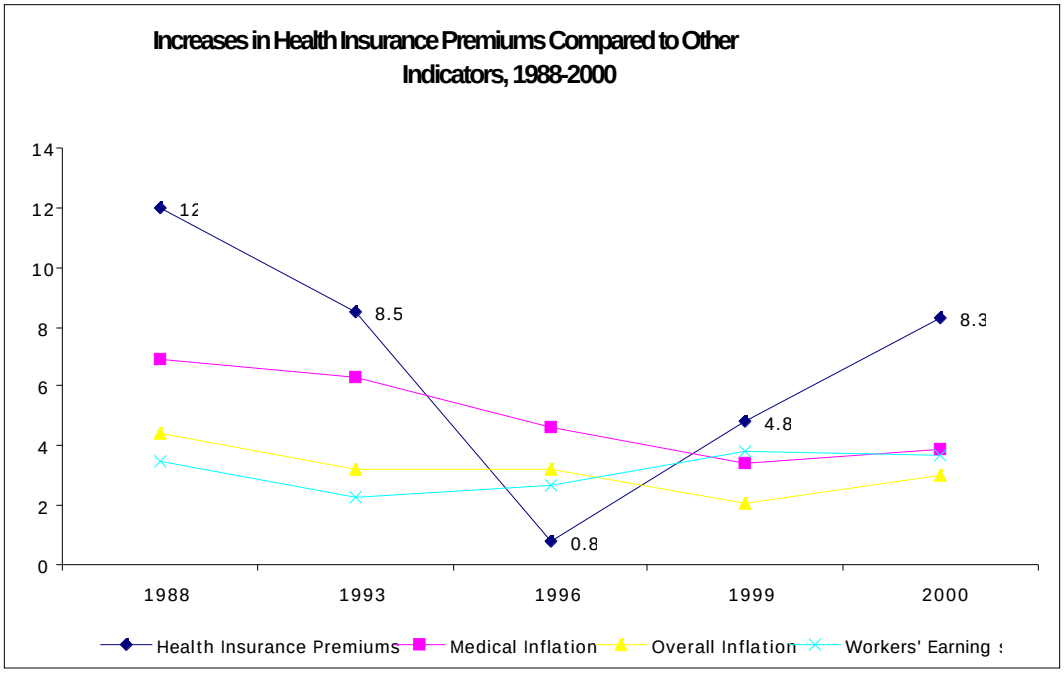
Mandated Benefits: Persons Covered Ranked by State from Most to Least		
RANK	***STATE***	***NUMBER OF PERSONS COVERED***
1	Minnesota, North Dakota, Texas	8
4	Connecticut, Florida, Georgia, Utah	7
8	Arkansas, Illinois, Louisiana, Maryland, Montana, New York, Oregon, Virginia, Wyoming	6
17	California, Kansas, Maine, Nebraska, Nevada, New Mexico, North Carolina, South Dakota, Tennessee, Vermont, Wisconsin	5
28	Arizona, Colorado, Hawaii, Idaho, Indiana, Iowa, Kentucky, **Massachusetts**, Mississippi, Missouri, New Hampshire, Ohio, Oklahoma, South Carolina	4

Source: Blue Cross and Blue Shield Association, December 1999.

List of Mandated Benefits in Massachusetts

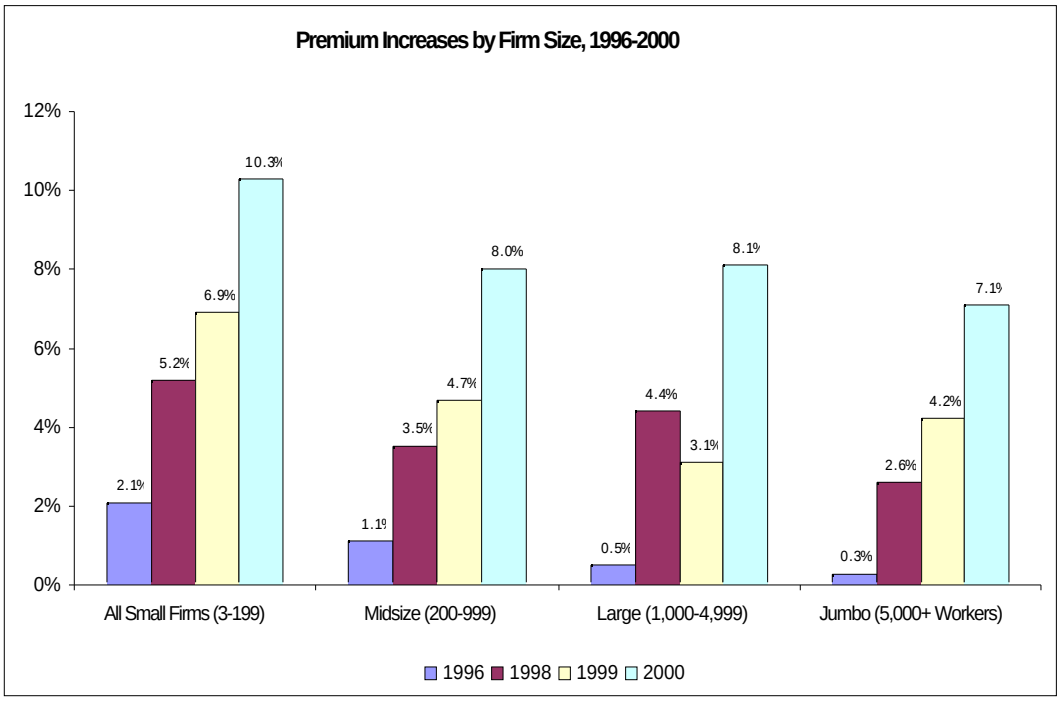
Benefits Mandated: alcoholism treatment, blood lead screening, bone marrow transplants, breast reconstruction (federal mandate), cervical cancer screening, formula for PKU, hair prosthesis, home health care, in vitro fertilization, mammography screening, maternity, mental health (general), minimum maternity stay (federal mandate), off-label drug use, rehabilitation services, well-child care
Providers Mandated: chiropractors, dentists, nurse midwives, nurse anesthetists, psychiatric nurses, optometrists, podiatrists, professional counselors, psychologists, social workers
Persons Covered: adopted children, continuation of coverage/employees, handicapped dependents, newborns (every state covers)
Note: Massachusetts has no mandated offerings.

Figure 15:



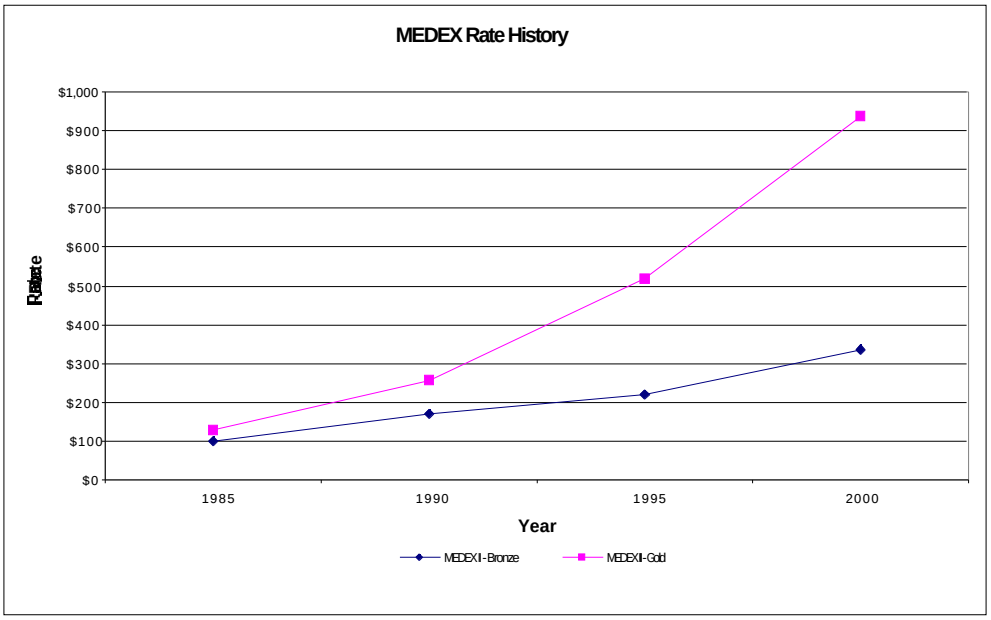
Source: KFF/HRET Survey of Employer-Sponsored Health Benefits: 1999, 2000; KPMG Survey of Employer-Sponsored Health Benefits: 1988, 1993, 1996

Figure 16:



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 1999, 2000; KPMG Survey of Employer-Sponsored Health Benefits

Figure 17:



Source: Massachusetts Division of Insurance